DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/08/2014 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING X4 1 D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) (K4)1 D PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (K 000) INITIAL COMMENTS (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY) (K 000) INITIAL COMMENTS (K 000) A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/10/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/03/14 Facility Number: 000191 Provider Number: 155294 AIM Number: NA		(X3) DATE S	CONSTRUCTION	(X2) MULTIPLE A. BUILDING 0	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		
NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING X44 ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION		R	A. BOILDING VI				
FORUM AT THE CROSSING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (K 000) INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/10/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/03/14 Facility Number: 000191 Provider Number: 155294 AIM Number: NA	3/2014	04/0		B. WING	155294		
INDIANAPOLIS, IN 46240 INDIANAPOLIS, IN 46240			REET ADDRESS, CITY, STATE, ZIP CODE	S		ROVIDER OR SUPPLIER	NAME OF PI
INDIANAPOLIS, IN 46240			05 WOODFIELD CROSSING BLVD	8		T THE CROSSING	FORUM A
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DIANAPOLIS, IN 46240	I.			
A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/10/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/03/14 Facility Number: 000191 Provider Number: 155294 AIM Number: NA	(X5) COMPLETION DATE		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
Code Recertification and State Licensure Survey conducted on 02/10/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/03/14 Facility Number: 000191 Provider Number: 155294 AIM Number: NA				{K 000}	3	INITIAL COMMENTS	{K 000}
Facility Number: 000191 Provider Number: 155294 AIM Number: NA					and State Licensure Survey 14 was conducted by the ment of Health in	Code Recertification a conducted on 02/10/1 Indiana State Departr	
Provider Number: 155294 AIM Number: NA					14	Survey Date: 04/03/1	
Sunyayar: Mark Carabar Life Safety Code						Provider Number: 15	
Surveyor: Mark Caraher, Life Safety Code Specialist					aher, Life Safety Code		
At this PSR survey, Forum at the Crossing was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.					with Requirements for care/Medicaid, 42 CFR ife Safety from Fire and the ational Fire Protection 101, Life Safety Code (LSC),	found in compliance of Participation in Medic Subpart 483.70(a), Li 2000 edition of the Na Association (NFPA) Chapter 19, Existing I	
This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor, in resident rooms 421 through 428 and in resident rooms 614 through 630. The facility has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 74 and had a census of 54 at the time of this visit.					ction and fully sprinklered. alarm system with smoke dors, in all areas open to the ooms 421 through 428 and 4 through 630. The facility smoke detectors in all other ms. The facility has a ad a census of 54 at the time	Type V (111) construct The facility has a fire detection in the corrid corridor, in resident roin resident rooms 614 has battery operated resident sleeping room capacity of 74 and has of this visit.	
All areas where the residents have customary access were sprinklered and all areas providing					_		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6)	X6) DATE		TITLE		SUPPLIER REPRESENTATIVE'S SIGNATURE	DIRECTOR'S OR PROVIDER/S	LABORATORY

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 000191

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/08/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDI	TIPLE CONSTRUCTION NG 01	(X3) DATE SURVEY COMPLETED		
		155294	B. WING _			R 04/03/2014	
NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING				STREET ADDRESS, CITY, STATE, Z 8505 WOODFIELD CROSSING BI INDIANAPOLIS, IN 46240		1 04/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE TO THE APPROPRIA		
{K 000}			{K 0	00}			